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Introduction

Chicot Memorial Medical Center, a critical access hospital located in the city of Lake Village in Chicot County, Arkansas, is a 501 (c) 3 not for profit organization. In order to fulfill the hospital's mission and retain tax exempt status, it must provide programs and services that intentionally assess and respond to local community health needs. Chicot Memorial Medical Center provides community benefits by offering health education, free community health screenings, a free community center offering exercise classes, support for local athletic activities, and community health initiatives. Further, every three years CMMC conducts a survey assessing the needs of Chicot County residents and hospital stakeholders in the surrounding area. The assessment includes input from persons representing broad interests of the community served by the Chicot Memorial Medical Center, including those with public health expertise. These individuals form the community advisory committee. The community advisory committee assisted hospital staff in collecting survey data that indicate the most pressing health concerns in the hospital service area. Upon identifying the health issue priorities, the Chicot Memorial Medical Center's community needs assessment steering committee will create an action plan to address some of these issues through resources available to the hospital. The completed report will be made available to the public. The Chicot Memorial Medical Center's 2019 Community Health Needs Assessment is prepared by Mellie Bridewell, CEO of Arkansas Rural Health Partnership, in accordance with the requirements of Section 9007 of the Patient Protection and Affordable Care Act of 2010.

Health Care in 2019

This Community Health Needs Assessment was prepared during a period of transition and uncertainty both in the health care industry and the political environment in the country. Healthcare—a sector that accounts for one-sixth of the U.S. economy—contributes to the biggest tensions between economics and politics and remains a concern for millions of families. This is true for the past few years and will continue to be so in 2019 moving forward.

Healthcare issues . . .

Healthcare Reform isn't over, it's just more complicated: Politicians and policymakers at the state level may be making key decisions in healthcare if many healthcare reforms are enacted. Health organizations need to focus on understanding how policies will affect their business financially. One example looking forward will include reimbursement on telehealth services.

The healthcare industry tackles the opioid crisis: More and more emphasis will be put on helping patients stop addictions and regulating physicians on prescriptions. Data sharing across government agencies will be able to locate and target patients with addiction problems.

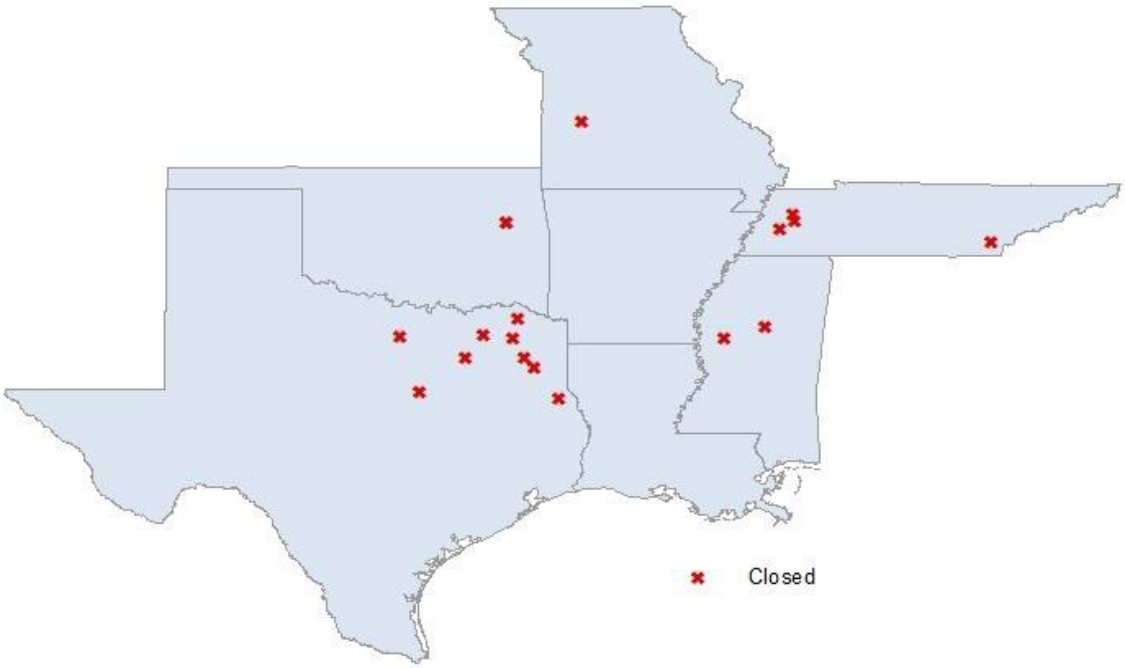
Medicare Advantage swells: The federal government is ramping up Medicare Advantage plans and to avoid penalties, health insurers should manage risk by focusing on members, paying particular attention to services such as timely member notifications, an adequate network, and up-to-date provider directories.

Securing the Internet: There will be more cybersecurity breaches and hospitals and health systems must be prepared. The financial and reputational cost of a breach affecting patient health can exceed the lost revenue from interruption of business.

Rural Hospital Closings: One of the biggest concerns for rural hospitals is the closing of so many of these facilities across the country. Eighty-nine rural hospitals have closed since 2010, and those closures are spread across 26 states, according to research from the North Carolina Rural Health Research Program. Of the 26 states that have seen at least one rural hospital close since 2010, those with the most closures are located in the South, according to research from the North Carolina Rural Health Research Program. Seventeen hospitals in

Texas have closed since 2010, the most of any state. Tennessee has seen the second-most closures, with nine hospitals closing since 2010. In third place is Georgia with seven closures. Across the U.S., more than 600 rural hospitals are vulnerable to closure, according to an estimate from iVantage Health Analytics, a firm that compiles a hospital strength index based on data about financial stability, patients and quality indicators.

Rural Hospital Closings in Surrounding States



Exciting trends and innovation ….

Across the healthcare sector, 2019 will be a year of value-based care as we expect the "outcomes-based care" focus to become more global and healthcare industry to continue to transition to the value-based model. It is anticipated that up to 15% of global healthcare spending will be tied in some form with value/outcome based care concepts. (Forbes Health News). During 2019, the application of digital health will continue to go far beyond the traditional system and empower individuals to be able to manage their own health. Increasing cost burden from chronic health conditions and aging population will be the chief driver for digital health solutions. Furthermore, favorable reimbursement policies towards clinically relevant digital health applications will continue to expand care delivery models beyond physical medicine to include behavioral health, digital wellness therapies, dentistry, nutrition, and prescription management.

Common to healthcare will be telehealth services expanding from emergency and specialty practices to bring telehealth technology to clinical use cases such as elderly care, chronic condition management, and mental/behavioral health. Telehealth- also known as telemedicine- will become a significant part of the healthcare system. Not only will telehealth provide convenience for patients and family members, especially in rural communities, but it is positive for the hospital's bottom line. Telehealth will enable hospitals to monitor patients once they are home or in many cases allow patients to go home earlier with the hospital providing monitoring and mobile health teams to respond and check on patients.

Hospitals will continue to be crucial in communities to provide acute, complex care; including handling emergencies and performing surgeries. Smaller, rural hospitals will adapt by diversifying and possibly becoming part of larger health systems. Instead of all hospitals providing all services; hospitals will work together to specialize and create specialty hubs that are geographically dispersed across an entire market area. Keith Mueller, director of the RUPRI Center for Rural Health Policy Analysis, said he expects smaller hospitals- both rural and urban- to continue to affiliate with other hospitals. This will give them the larger scale they need for greater purchasing power, delivery of services, and negotiating with insurers. While rural hospitals have started to partner with large urban health centers, they are beginning to partner with other rural hospitals and rural community health centers.

Healthcare everywhere: Mobile health applications, telemedicine, mHealth, remote monitoring, and ingestible sensors generating streams of data will allow doctors and patients themselves to track every heartbeat, sneeze, or symptom in real time. The following are predicted healthcare trends of 2020:

ERA OF DIGITAL MEDICINE	**FOCUS ON PREVENTATIVE CARE**
Medical Care is no longer confined to clinicians in clinics and hospitals; Telemedicine enabled e-visits, mHealth, and tele-monitoring; Virtual doctor-patient contact; Sensor Technology	Focus on long-term prevention and management; Awareness campaigns and behavioral nudges toward healthy habits; Encouragement of healthy behavioral habits
COMPLIANCE & PATIENT SAFETY	**GROWTH OF TELEMEDICINE**
Technology to assess quality, safety, and effectiveness of medicine; New Regulatory Demands automating regulatory process and surveillance; Empowered consumers (patients) with their own information	Communication infrastructure improves to extend healthcare; Local physicians can consult with specialists; consumers can receive specialty care at local level; provides more services to be delivered at the local level creating provider networks to form

EXPANDED DEFINITION OF HEALTH Healthcare systems evolve from sick care to wellness; Nutrition, behavioral, environmental and social networks are vital foundations; Convergence of physical and behavioral medical management	**OUT-COME BASED PAYMENT** Price of care linked to the value of the performance or outcome; Payment driven by hospital re-admissions or patient ratings; Doctor's payment linked to patient's health; Holding medical practitioners accountable
COMMUNITIES AS HEALTH CARE PROVIDERS Aging population & growing disease burden raise the demand for skilled health care professionals; creating a shortage; Healthcare systems increasingly rely on community outreach, peer-support and family care-giving to supplement care	**RISE OF PRIVATE INSURANCE EXCHANGES** Private players form health insurance exchanges; New exchange products offered through technology offer customers more options; Private exchanges match public ones and offer competitive prices
INTEGRATED CARE Accountable care organizations, patient-centered medical homes, outcome-based payment models, providers, physicians, and payers join together to provide patients with bundled services at lower cost; Hospital-physician alignment allows prioritized treatment for patients requiring urgent care	**HEALTH CARE ROBIOTICS** Robots sterilize surgical tools without human intervention, reducing incidences of infections and freeing up hospital staff time; Robotic system dispense drugs in pharmacies with zero errors; Automated kiosks allow patients to enter medical symptoms and receive customized recommendations and information
PARTICIPATORY MEDICINE Patients use their own health data to make better decisions. Apps designed to help people better manage their health, share best practices with fellow patients and lower medical costs by tapping into the knowledge of the crowd.	**3D PRINTING IN HEALTHCARE** 3D printing technology revolutionizes surgical practices, giving practitioners access to identical replicas of certain body structures- and eventually organs. It reduces surgical errors and improves rehabilitation in post-op. Joint replacements become cheaper.
HOLOGRAPHY-ASSISTED SURGERY Specialized surgeons perform holography-assisted surgery to treat patients remotely and instruct other physicians on operating procedures; Makes surgery less invasive and potentially offers better outcomes for patients, while also freeing up surgeon time.	**THE M HEALTH REVOLUTION** Mobile phones and growing health needs make "mHealth" affordable and easily accessible alternatives to traditional healthcare; Advanced mHealth applications include telemedicine, sophisticated diagnostics through attachments plugged into smartphones, personalized services and self-monitoring.
SOCIAL MEDIA- THE NEW HEALTH EXCHANGE Health care organizations engage with patients through social media, regularly gauging their needs and driving them to appropriate products	**EVIDENCED-BASED CARE** Doctors use databases to diagnose and treat patient conditions from electronic medical records (EMRs) which provide best treatment

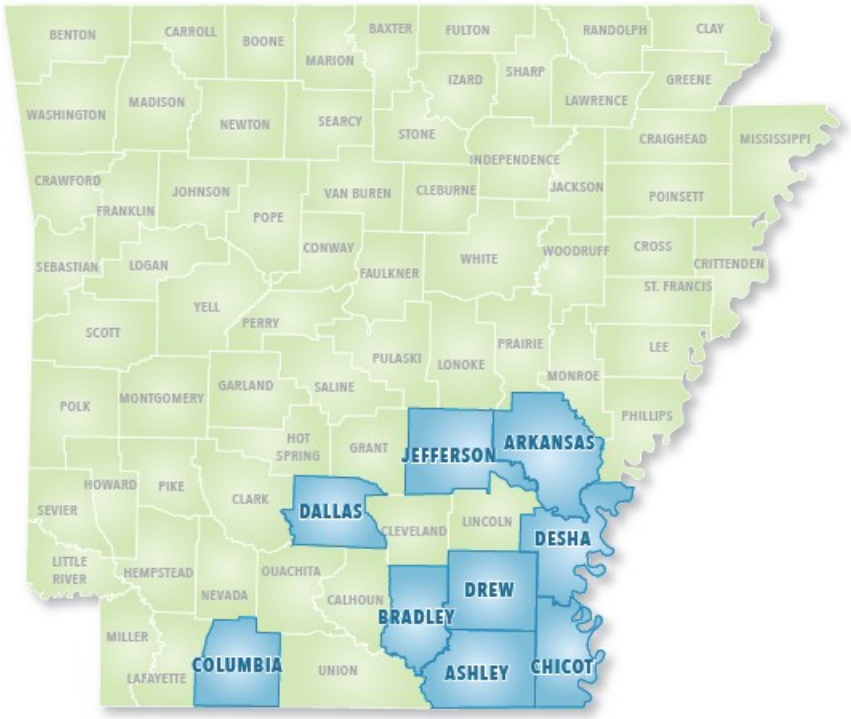
and services; Online patient communities grow providing needed information and navigation for patients to services and resources	options; 2020 sees the creation of warehouses of health data which will assist with identifying patterns and inform public health decisions and research
REMOTE MONITORING Sensor-enabled remote monitoring devices transmit patient biometrics to physicians and other caregivers in real time; Use of ingestible "smart pills" with sensors to wirelessly relay information on health indicators within the body to a smartphone	**REAL-TIME CLINICAL INFORMATION** Advanced data sharing networks allow insurance companies/payors and providers to access real-time patient information allowing health plans to assess the quality of care offered based on patient diagnosis and treatment
HOSPITAL & CLINIC COLLABORATION Hospitals and clinics are merging, both in urban and rural settings, due to changes in integrated care and reimbursement structure; Rural hospitals, especially, will see clinics diversify in hospital settings to address mental and behavioral health along with primary care	**HOSPITAL TRANSITIONS** Rural hospitals, specifically, will transition and diversify; there will be fewer hospital beds in the small rural hospitals and services such as rehabilitation, mental and behavioral health (in-patient and out-patient), emergent care, and primary care services will be offered in these facilities

The recommendations in this report should be considered with respect for the uncertainties, trends, and changes noted above.

Relevant Data

Regional & State

For the purposes of this assessment, regional demographics include the counties in which all Arkansas Rural Health Partnership hospital members are located which includes nine counties in the south Arkansas Delta: Arkansas, Ashley, Bradley, Chicot, Columbia, Dallas, Desha, Drew, and Jefferson. The estimated size of the general population within the nine service area counties is 205,800 residents (US Census, 2016).



The geographic region is known as the south Arkansas Delta which borders the Mississippi River and predominantly covers the southeast side of the state of Arkansas. The flat landscape of the service area borders the Mississippi River, which is a significant transportation artery connecting the Missouri and Ohio River tributaries (World Atlas, 2017). The flat, fertile land is the backbone of predominant industry in the region: agriculture and agribusiness. The region is very rural; Pine Bluff is the largest town in the Delta, home to about 42, 984 residents (US Census, 2017). Every county within the service area is designated as a Medically Underserved Area (HRSA Data Warehouse, 2018).

Within the service area, approximately 6.0% average of the general population is below the age of five (ranging from 5.1% in Dallas County and 6.9% in Desha County). This is

slightly below the state and U.S. averages for the age bracket. Increasing the age parameters to persons under 18 years of age shows another perspective of the number of children below 10 years. The average percentage of persons under 18 years in the service area is 22.6%, which is the same as the U.S. and slightly lower than the state. Ranges within the service area include 20.7% in Columbia County and 25.8% in Desha County. To further estimate the target population, new approximations from the Office of Adolescent Health were considered, which shows that adolescents (individuals age 10-19) make up approximately 13.2 percent of the U.S. population (The Changing Face of America's Adolescents, Office of Adolescent Health, HHS, 2018). The focus of SUD prevention, treatment, and recovery planning efforts will focus on adolescents (beginning at age 10) and adults in the service area, roughly estimated to be about 90% of the service area population.

Demographic & Socioeconomic Profile Comparison (County, State, Nation)

Region	Population	Median Household Income	Unemployment	Persons Living in Poverty	Adults (18-64) w/ health insurance	Children & Youth (0-18) w/ health insurance
Arkansas County	19,019	$36,352	3.9%	18.1%	87%	95%
Ashley County	21,853	$30,717	5.9%	17.9%	88%	95%
Bradley County	11,508	$34,665	5.7%	23.5%	82%	93%
Chicot County	11,800	$29,628	8.6%	30.1%	85%	95%
Columbia County	24,552	$36,507	5.0%	24.2%	87%	95%
Dallas County	8,116	$35,745	4.8%	20.8%	89%	96%
Desha County	13,008	$26,519	5.2%	26.5%	86%	95%
Drew County	18,509	$33,092	5.5%	19.2%	87%	96%
Jefferson County	77,435	$36,377	5.5%	23.3%	89%	97%
Service Area	*205,800 total*	*$33,289*	*5.6%*	*22.6%*	*87%*	*95%*
State of Arkansas	**3,004,279**	**$42,336**	**3.7%**	**17.2%**	**86**%	95%
U.S.	323,127,513	$59,039	4.1%	12.7%	85.2%	94.3%

(US Census, 2017; Bureau of Labor & Statistics, December 2018)

Health disparities, poverty, lack of transportation, low educational attainment, poor access to health care, and poor health outcomes- the Mississippi Delta Region represents an amalgam of societal difficulties that affect each of its residents. One Delta state's Office of Minority Health publication states that health disparities of the people living in the Delta are "due to gaps in access to care and an inadequate public health infrastructure – especially difficult to maintain in the small, isolated, rural communities that make up so much of the Delta region (Graham, 2008)." On average, one in four persons in the service

area is living below poverty level, making it one of the poorest areas of the state.

According to recent US Census Data (2017), individuals within the service area experience greater economic hardship compared to those in other regions of the state and nation. This includes a lower median household income and higher poverty rate. This can be contributed to lower levels of educational attainment, with most county residents having lower high school graduation rates compared to the state and nation. Unemployment is also significantly higher in eight out of nine service area counties as compared to the state and nation.

The majority of Southeast Arkansas Delta residents are Caucasian (*average of 59%*), which is less than the state (*78%*). African Americans are the largest minority in the service area (*average of 37%*), which is significantly higher than the state (*15%*). The Hispanic population is small, but growing (*average of 4% in service area vs. 7% across state)*.

Race & Ethnic Diversity Profile Comparison (Service Area Counties & State)

Region	Black	White	Hispanic	Total Population
Arkansas County	4,554 (25%)	13,223 (73%)	565 (2%)	18,214
Ashley County	5,184 (25%)	14,816 (72%)	1,066 (5%)	20,492
Bradley County	3,100 (15%)	7,508 (68%)	1,638 (15%)	10,992
Chicot County	5,987 (55%)	4,739 (43%)	602 (6%)	10,945
Columbia County	8,383 (36%)	14,312 (61%)	619 (2.7%)	24,552
Dallas County	3,137 (42%)	4,138 (55%)	239 (3%)	7,469
Desha County	5,629 (47%)	5,974 (50%)	724 (6%)	11,876
Drew County	5,222 (28%)	12,962 (70%)	578 (3%)	18,651
Jefferson County	39,629 (57%)	28,567 (41%)	1,400 (2%)	70,016
State of Arkansas	**469,155 (15%)**	**2,372,669 (78%)**	**218,142 (7%)**	**2,988,248**

(United States Census Bureau, Population Estimates, 2016)

Health Disparities in the Service Area. Health disparities within the state of Arkansas are literally making headlines and the differences are easily noticeable with a glimpse of a map. In 2018, individuals living in northwest Arkansas experienced life expectancies of ten years or more than their rural, eastern Arkansas neighbors. In fact, the life expectancy of individuals in the service area are some of the poorest in the state. This is based on many factors, including differences in physical activity, smoking, preventable hospital stays, and violent crime rates (County Health Rankings and Roadmaps, 2018). Perhaps the most critical determinant of these factors is access, including access to education, employment, transportation, and healthcare providers (preventive, primary & emergent services). See Table 5 below.

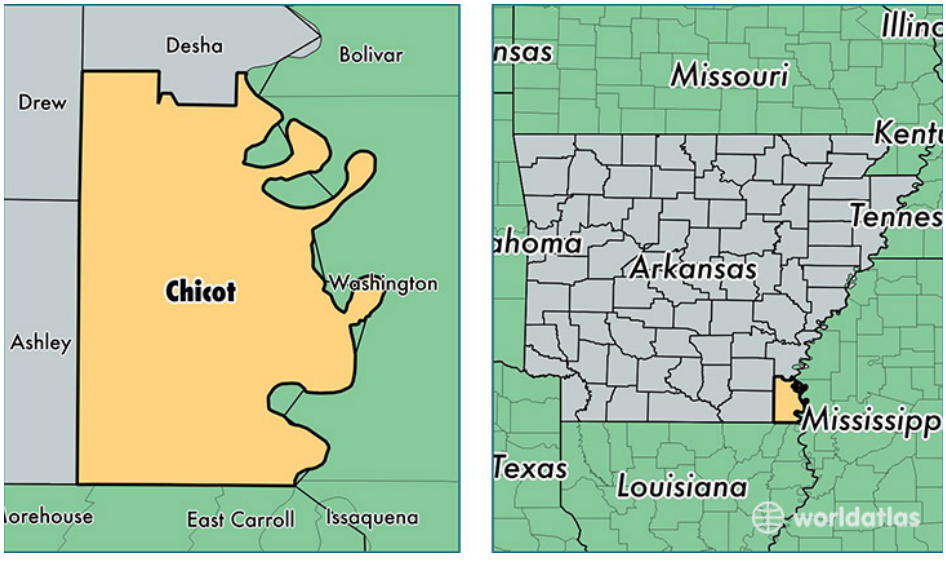
2018 County Health Rankings: Measure Comparison (Nation, State, Service Area)

Measure	Description	US Median	State Overall	Service Area Min.	Service Area Max.	Service Area Ave.
Health Outcomes						
Premature death	Years of potential life lost before age 75 per 100,000 population	6,700	9,200	10,100	12,800	11,333
Poor or fair health	% of adults reporting fair or poor health	16%	24%	23%	30%	26%
Poor physical health days	Average # of physically unhealthy days reported in past 30 days	3.7	5.0	4.7	5.6	5.06
Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	3.8	5.2	4.7	5.2	4.98
Clinical Care						
Uninsured	% of population under age 65 without health insurance	11%	11%	9%	15%	10.77%
Primary care physicians	Ratio of population to primary care physicians	1,320:1	1,520:1	2,980:1	1000:1	1,825:1
Mental health providers	Ratio of population to mental health providers	1,480:1	490:1	11,000:1	160:1	1,898:1

(County Health Rankings & Roadmaps: 2018 County Health Rankings: Arkansas

Chicot County

Chicot County is located at the most southeast corner in the state of Arkansas on the border of Louisiana and Mississippi on the Mississippi River.



According to the Robert Wood Johnson Foundation County Health Rankings and Roadmap study, Chicot County is considered one of the unhealthiest counties in the state of Arkansas; ranking #69 in health outcomes and #70 in health factors out of 75 counties in Arkansas. The

chart below demonstrates Chicot County's ranking in demographics, economics, injury, health indicators, and health risk factors.

Demographics	Description	Number	Percent	Rank	State %
Total Population	The number of people who live in the county.	11,189	N/A	59	0.4%
White (Non-Hispanic)		4,379	39.1%	74	73.4%
Black (Non-Hispanic)		6,067	54.2%	4	15.4%
Hispanic or Latino Origin		578	5.2%	21	7.0%

U.S. Census Bureau, 2012-2016 Population Estimates: Ranks are based on the percent of the total population. Ranks are 1= highest and 75 = lowest.

Economic Indicators	Description	Number	Percent	Rank	State %
Median Household Income	The income at which half the households earn more and half the households earn less.	$29,628	N/A	72	$42,336
People of All Ages in Poverty	People of all ages living below the Federal Poverty Line (FPL).	3,457	30.9%	73	18.8%
Children in Poverty	Children under age 18 living below the Federal Poverty Line (FPL).	1,111	43.7%	68	26.8%
Children in Single Parent Homes	Children that live in a household headed by single parent.	1,301	51.2%	68	35.4%
Uninsured	Population under age 65 without health insurance.	1,343	15.9%	47	14.5%
No transportation	Households with no transportation.	647	14.8%	73	6.4%

Injury*	Description	Number	Rate	Rank	State Rate
Injury Related Hospital Discharges	All injury related hospital discharges.	227	374.8	17	512.6
Unintentional Fall Discharges	Hospital discharges from falls due to loss of balance and not due to paralysis or injury.	95	129.3	11	222.8
Motor Vehicle Accident Discharges	Hospital discharges from motor vehicle accidents including cars, motorcycles and ATVs.	30	57.8	27	69,5
Traumatic Brain Injury Discharges	Hospital discharges due to injury resulting from external mechanical forces.	8	11.3	16	20.9
Deaths from Injury	Deaths from intentional and unintentional (accidental) injuries, 5-year average.	11	91.1	45	78.5

**When low numbers result in unstable injury or death rates, rates are not displayed. Rank was calculated for those counties where rates were available. Rates are per 100,000 population. Injury related discharges are 5-year averages. 5-year average indicates the average number of annual deaths for the most recent 5 years of available data.*

Health Indicators†	Description	Number	Percent	Rank	State %
Current adult smokers	Adults (18 +) reporting being current smokers.	1,987	23.4%	66	24.9%
Current youth smokers	Students grades 6-12 reporting being current smokers.	12	1.8%	2	5.6%
Low Birth-Weight Babies	Live births where the infant weighed less than 2,500 grams (5 lbs., 8 oz.), 5-year average.	14	10.6%	60	8.8%
Life Expectancy	The average expected life time (in years) from birth.	74.2 yrs.	N/A	52	76.0 yrs.
Natural Teeth	Adults 65+ who have had all their natural teeth extracted.	2,600	30.8%	66	23.0%
Water Systems with Fluoridation	Public water systems containing enough fluoride to protect teeth.	7	87.5%	7	49.7%
		Number	Rate	Rank	State Rate
Infant Mortality, 2012-2016	Measures the number of deaths among children less than one year of age .	4	6.1	26	7.1
Teen births	Births to mothers aged 15 to 19 years, 5-year average.	14	44.7	35	39.5

†5-year average is shown for low birth-weight babies and teen births and indicates the number of births on average each year for the most recent 5 years of available data; Infant mortality number is the total number of deaths over the most recent 5 years available and infant mortality rate is an estimate of the number of infant deaths for every 1,000 live births; Teen birth rates are per 1,000 female population ages 15-19 years.

Major Health Risk Factors	Description	Number	Percent	Rank	State Rate
Food Insecurity	The population who did not have access to a reliable source of food during the past year.	3,170	27.9%	74	18.4%
Physical Inactivity	Adults (Age 18+) reporting no leisure-time physical activity .	2,849	33.7%	36	32.5%
Obesity (adults)	Adults (Age 18+) reporting being obese (BMI >= 30.0)	3,385	40.1%	55	35.7%
Overweight (adults)	Adults (Age 18+) reporting being overweight (BMI >=25.0 - 29.9).	2,948	34.9%	42	32.5%
Obesity (youth)	Students grades K-10 with a BMI >= 95th percentile for age and sex.	608	32.8%	75	22.0%
Overweight (youth)	Students grades K-10 with a BMI >=85th percentile to <95th percentile for age and sex.	342	18.4%	56	17.0%
Low Health literacy	Adults with basic or below basic health literacy skills.	4,644	53.4%	75	37.1%
Substance Abuse (youth)	Students grades 6-12 reporting using drugs in the past 30 days.	47	7.0%	13	9.9%

Relevant to this assessment, one must take into consideration a few key rankings to point out:

- Chicot County ranks 75 out of 75 in Obesity
- Chicot County ranks 75 out of 75 in Low Health Literacy
- Chicot County ranks 74 out of 75 in Food Insecurity
- Chicot County ranks 73 out of 75 for Poverty
- Chicot County ranks 73 out of 75 in households with no transportation
- Chicot County ranks 72 out of 75 in median household income

Topic Specific Data

At the conclusion of the Chicot Memorial Medical Center survey and community advisory board processes, there were three priorities that were targeted for the hospital to address over the next three years: **Mental and Behavioral Health Services, Patient Navigation, Health Food Options, and Physician Recruitment,** The following data highlights the issues around these topics at the federal state, and local level.

Mental and Behavioral Health Services

Poor mental and behavioral health have long been a major concern for communities across the nation. Stigma surrounding mental health and the lack of understanding and/or misunderstanding related to prevention and treatment options often keep individuals from seeking needed interventions before symptoms accelerate into a mental health crisis or even death. In rural communities, these issues are exacerbated as prevention, early detection, and treatment options related to mental health are limited. The number of mental health professionals are often extremely limited in rural settings, leaving crisis management and treatment responsibilities to poorly equipped laypersons, first responders, and health care professionals.

According to the CDC, the #10 leading cause of death in the nation for 2014, 2015, and 2016 was intentional self-harm (suicide). Interestingly enough, intentional self-harm held the same placeholder for the #10 national leading cause of death in 1980. In each year noted, suicide was the only leading top 10 cause of death that could be linked to poor mental and/or behavioral health. In comparison, a National Vital Statistics Report recently released by the CDC titled *Major Causes of Death, by County* showed that poor mental and/or behavioral health could be attributed to **three out of ten leading causes of death** in service area counties between 1980 and 2014. See table below for leading cause of death rankings by service area.

Top Ten Leading Causes of Death Linked to Poor Mental and/or Behavioral Health, Service Area Counties

Leading Cause of Death	Arkansas County	Ashley County	Bradley County	Chicot County	Desha County	Drew County	Dallas County	Jefferson County
Self-harm & interpersonal violence	#7	#8	#8	#8	#8	#8	#8	#7
Cirrhosis & other chronic liver diseases	#9	#9	#9	#9	#9	#9	#9	#9
Mental & substance use disorders	#10	#10	#10	#10	#10	#10	#10	#10

(Major Causes of Death, by County, US County-Level Trends in Mortality Rates for Major Causes of Death, 1980-2014, National Vital Statistics, CDC, 2016)

In a report released in April 2016 by the Arkansas Department of Health, suicide is the leading cause of injury related deaths for Arkansans between the ages of 20 and 64 and the second leading cause of death among all other age groups according to Suicide Statistics Among Arkansans from 2009 to 2014 conducted by the Arkansas Department of Health, 2016. Suicide is a preventable cause of death. According to the 2017 State of Mental Health in America report, Arkansas ranks number 37 out of 51 with high prevalence of Mental Health illness. However, Arkansas ranks 44 in access to care. The rank shows that despite the high prevalence, access to care is low (National Alliance for the Mentally Ill, 2017).

Partner hospitals highlighted the number of patients within the target population utilizing the ED, as well as those seeking out care for mental/behavioral health problems. See Table below.

Emergency Department Use in Service Area, Total vs. Mental Health Complaint

Emergency Department Use	2015	2016
Total number of patients utilizing the ED	88,673	89,965
Total number of patients (age 18-64) utilizing the ED	56,303	54,837
Number of patients (age 18-64) utilizing the ED for mental health/behavioral health problems	1,121	1,241

(This data includes 8 out of the 10 participating hospitals)

Hospital administrators have heard the complaint from healthcare providers within the ED that there is limited ability to correctly screen patients for psychiatric and mental health concerns. A dedicated mental health professional (via telemedicine) will significantly relieve the ED staff from completing these assessments, while also decreasing the hold time for these patients in the ED waiting for the assessment to be completed.

Emergency Department Psychiatric & Mental Health Screening Efforts

Screening & Assessment	2015	2016
Number of patients (age 18-64) undergoing a formal psychiatric evaluation in the ED	353	471
Number of patients (age 18-64) given a mental health screening/assessment in ED	1,108	1,233

(This data includes 8 out of the 10 participating hospitals)

Rural communities face distinct challenges in addressing mental and behavioral health concerns and their consequences. ARHP consortia members recognize that they have all the challenges listed:

- Behavioral and mental health resources and services are not as readily available and are often limited.
- The number of mental health professionals are very limited in rural areas, increasing access barriers for individuals in need of specialized care.
- Patients who require treatment for serious mental illness may need to travel long distances to access these services. This includes in-patient and out-patient treatment, as well as hospitalization for psychiatric diagnoses. Transportation from the emergency department to treatment facilities is often limited to EMS. In some counties, one or two EMS trucks cover an entire county with a one-hour driving radius.
- Rural first responders and rural hospital ED staff may have limited experience in providing care to a patient presenting in a mental health crisis.
- Prevention programs may be spread sparsely over large rural geographic areas.
- Patients seeking mental health treatment may be more hesitant to do so because of privacy issues associated with smaller communities.
- Stigma is a great concern for individuals in need of accessing treatment services, particularly in rural areas where everyone knows that there are very limited locations to access services. Patients avoid care due to what their friends or neighbors will think if they see them enter the doors of a mental health department or therapist's office.

Need for Patient Navigation Services

According to recent US Census Data (2016), individuals within the service area experience greater economic hardship compared to those in other regions of the state and nation. This includes a lower median household income and higher poverty rate. This can be contributed to lower levels of educational attainment, with most county residents having lower high school graduation rates compared to the state and nation. Unemployment is also significantly higher in seven out of eight service area counties as compared to the state and nation. These social determinants of health compound to negatively impact the safety of residents as the service area reports some of the highest violent crime rates in the state.

Demographic & Socioeconomic Profile Comparison (County, State, Nation)

Region	Median Household Income	Persons Living in Poverty	High school graduation	Unemployment
Arkansas County	$36,411	20.7%	85%	4.4%

Ashley County	$34,263	19.6%	82%	8.0%
Bradley County	$33,701	28.0%	81%	6.2%
Chicot County	$28,913	31.4%	92%	9.4%
Dallas County	$34,084	21.3%	93%	7.4%
Desha County	$27,197	30.9%	85%	7.6%
Drew County	$32,819	21.2%	86%	7.1%
Jefferson County	$36,747	26.5%	83%	7.2%
State of Arkansas	**$41,371**	**17.2%**	**85%**	**5.2%**
U.S.	*$53,889*	*12.7%*	*88%*	*5.3%*

(US Census, 2016, 2017 County Health Rankings: Measures and National/State Results, Arkansas: Compare Counties)

For many of the people that are qualifying for the new public health coverage programs and those that are newly qualified for Medicare, this is the first time they have had to apply for and navigate the public assistance system. These changes can be very scary, especially for elderly residents who are unsure of who to turn to for assistance. It can also be unsettling for those that have held jobs with insurance and are proud that they have not had to access public assistance programs. It is these residents that need to be educated and assisted through this process more than anyone.

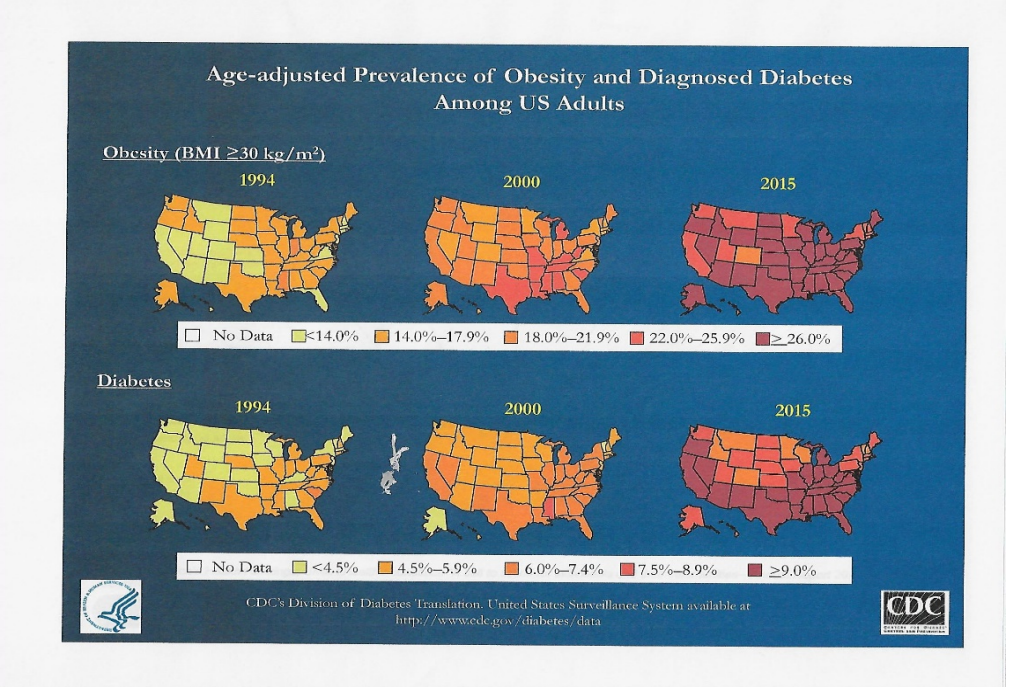
Many factors have caused the need for patient navigation services through the hospital in the service area; specifically assistance programs including insurance, Medicare, prescription assistance, SNAP, and housing. Other factors include:

- A high percentage of individuals make negative lifestyle choices including smoking, poor nutrition, and lack of physical activity. Patients have multiple health issues and therefore that many needs in an insurance program.
- A low level of health care literacy can impede access to information on available services and present difficulty in getting residents to understand their insurance. The average Arkansas Delta residents reads at a 3rd grade reading level. This can cause major issues with helping them understand paperwork.
- Many small business workers lost their insurance and were told to get on the exchange. They have never not had insurance provided and many were embarrassed by the fact they had to access a government program. We often see this with Medicare residents as well. They have never had to use programs and are unsure of how to navigate these programs like those that have been on government programs for years.
- Once Arkansans were on the Arkansas program many individuals fell out of compliance and were dropped from their insurance either because they could not pay their premiums, they did not renew their plan, or they did not fulfill the work requirements put in place with the state Arkansas Works plan.

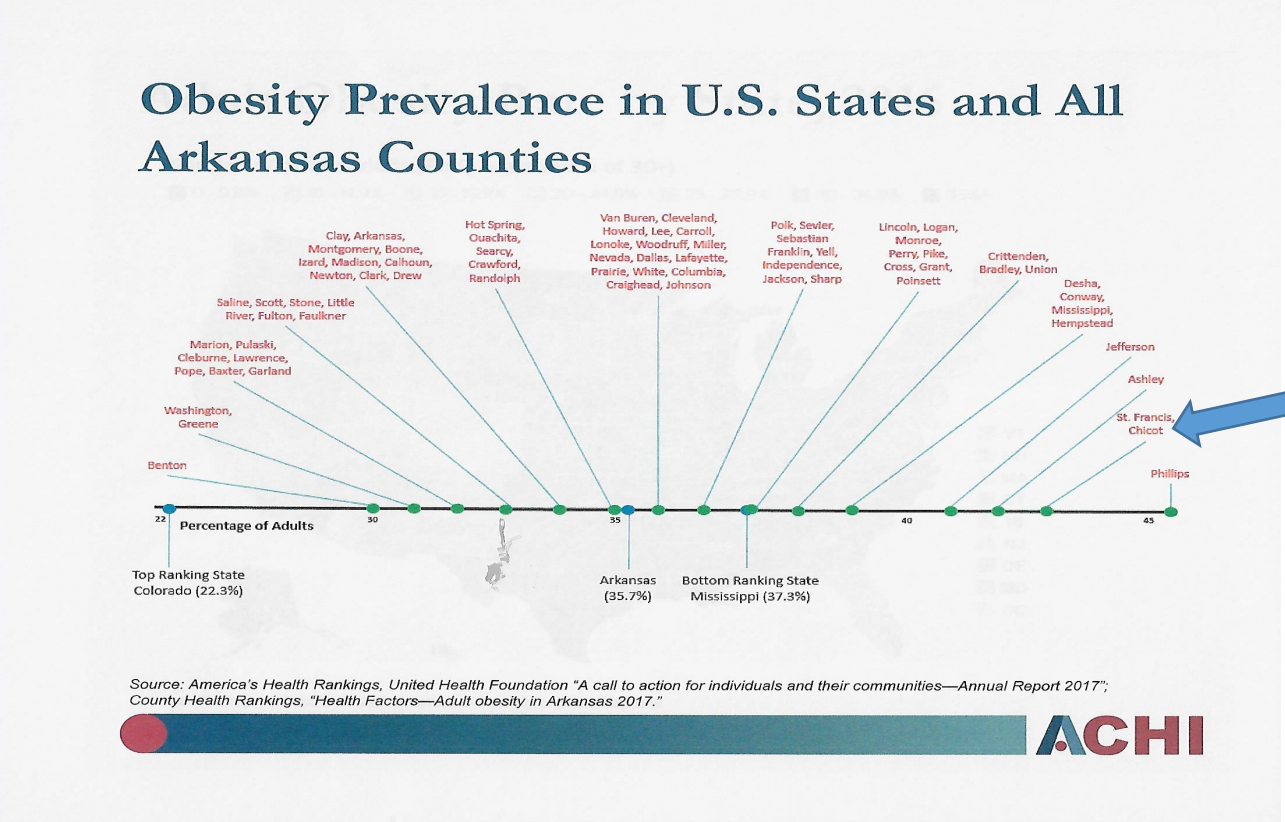
- Despite the significant improvement in the number of enrollment options, many consumers still prefer enrolling with the help of a trusted person or organization from their community. Rural residents are not as trusting of help that comes from the outside. They live in small communities and are not always open to getting assistance from a stranger.
- There have many insurance assisters in this region that came to assist residents, but are no longer available. Many of them went away when they no longer had federal funds or where cut once Arkansas mandated that no state funding could go towards Private Option enrollment efforts. There have been a lot of efforts to assist residents in this region with health programs that have gone away when the funding no longer exists.

Need for Healthy Food Options

In 2015, Arkansas had the highest adult obesity rate among all 50 states, according to a report on obesity from the Trust for America's Health and the Robert Wood Johnson Foundation. Nationally, more than 30% of adults are obese, a stark increase from 1980 when no state had a rate above 15%. In 1990, no state had an obesity rate above 20%. Now, obesity rates are at or above 30% in 22 states, according to the report. The upward trend in the prevalence of obesity and chronic disease resulting from obesity is staggering when visually depicted.



A follow-up report by the Trust for America's Health and the Robert Wood Johnson Foundation in 2017 analyzed figures from the Centers for Disease Control and Prevention and found a slight improvement for Arkansas in the rankings. Arkansas fell to number three tying with Alabama at 35.7 percent. According to United Health Foundation chart below, Drew County's obesity rate is lower than the state average. Drew County is also the only county in the Southeast Arkansas region that is not below the state average. All the other Southeast Arkansas Delta counties rank under Mississippi's 37.3%; with Jefferson, Ashley, and Chicot having obesity rates over 40%.



Recruitment of Health Care Providers

For over a decade, hospital partners across the service area have consistently identified health workforce shortages as a critical priority issue to address. Not only is there a lack of primary and specialty care physicians, but also mental health professionals. To make matters worse, many providers are aging out of jobs and into retirement, leaving vacancies that cannot be filled. Small rural hospitals with limited resources are forced to pay for costly locum providers to travel from urban centers to fill these gaps. Rural residents do not know or trust these out-of-area providers and often stop utilizing care because of this cultural disconnect. If local

hospital systems want to keep their doors open and keep providing services to their community members, it is critical that there is an increase in local, homegrown health professionals and administrators.

In May 2018, Arkansas Rural Health Partnership did a survey of the current availability of local providers in the service area this is included below.

Local Health Workforce within Service Area by County, May 2018

Health Workforce Professional Type	Arkansas	Ashley	Bradley	Chicot	Columbia	Dallas	Desha	Drew	Jefferson	Total
Dietician	1	2	3	1	2	2	1	1	1	**14**
Paramedic	8	10	3	10	5	4	3	20	12	**75**
Radiology Technician	6	12	6	6	1	5	5	6	6	**53**
Respiratory Therapist	6	9	5	4	11	4	3	7	20	**69**
Physical Therapist	1	4	1	3	3	1	2	2	2	**19**
Occupational Therapist	1	1	1	2	2	1	0	2	2	**12**
Speech Therapist/Pathologist	1	3	1	1	1	2	0	5	2	**16**
Social Worker	2	4	3	1	2	1	1	1	3	**18**
Mental Health Counselor	3	3	3	2	3	1	2	9	6	**32**
Health Information Management	2	5	1	6	8	5	4	9	12	**52**
Health Administrator	2	1	1	1	1	1	2	1	1	**11**
Dental Hygienist	2	7	2	1	8	1	0	8	40	**69**
Dentist	2	7	2	1	5	2	2	11	10	**42**
Psychiatrist	1	0	1	1	1	0	0	2	1	**7**
Primary Care Physician	5	6	6	3	8	2	6	5	16	**57**
Specialty Physician	2	5	1	5	6	0	0	4	20	**43**
General Surgeon	0	1	0	2	2	1	1	2	7	**16**
Total Local Health Workforce by County	**45**	**80**	**40**	**50**	**69**	**33**	**32**	**95**	**161**	**605**

Self-Reported Data, Hospital Partners, May 2018

The obvious observation is that there are behavioral health workforce shortages across the board in counties like Desha, Bradley, Chicot, and Dallas. A little less obvious, but very clear is the inability to retain health professionals due to lack of resources and facilities. While there is definitely the need to grow more behavioral and mental health providers in the Arkansas Delta region due to the inability to recruit; it is obvious that in counties, such as Jefferson County, the absence of mental and behavioral health facilities is causing local providers to obtain employment outside of the service area.

In this poor Arkansas Delta region, social, financial, and academic support are of utmost importance if students are going to succeed. The majority of high school students in the target area do not have the support structures in place to learn and be academically successful. Most students in the region do not have educated parents, the economic means to seek a

better education, and the necessary academic resources to assist them with their studies and testing skills. When a high school student only experiences an environment in which education is not prioritized and there is not a role model or encouraging mentor/parent in their life, their expectations are not very high for themselves. The poverty of the Delta region, the lack of parental guidance, and lack of prioritizing education in the home environment; all contribute to low test scores, low college admissions and applications, and, ultimately lack of healthcare professionals in the region.

Almost impossible to comprehend, there are multiple high schools/school districts in the service area with **less than 2%** of students meeting college readiness benchmarks. The combined mean of students meeting college readiness benchmarks for all subjects at Academy partner high schools in the service area is **less than 6%** (local data, 2018).

Percent of Students Meeting College Readiness Benchmarks per 2017 ACT, by School District

Participating School District	Math	English	Reading	Science	All Met
Crossett	14.4	30.6	22.5	12.6	5.4
Dermott	4.8	23.8	9.5	4.8	4.8
Drew Central	17.3	41.3	24.0	9.3	6.7
DeWitt	15.3	44.7	25.9	17.6	11.8
Dollarway	3.4	19.0	12.1	3.4	0.0
Dumas	11.8	45.1	15.7	10.8	6.9
Fordyce	12.5	33.3	20.8	14.6	8.3
Hamburg	18.5	29.2	16.2	10.8	8.5
Hermitage	7.4	22.2	18.5	7.4	7.4
Lakeside	12.1	34.5	17.2	5.2	1.7
McGehee	7.4	23.5	8.8	5.9	2.9
Monticello	17.7	42.7	22.6	17.7	6.7
Magnolia	15.3	36.3	17.8	19.1	8.9
Pine Bluff	3.3	13.4	4.0	1.8	0.7
Stuttgart	24.7	36.1	29.9	23.7	16.5
Warren	14.5	25.5	11.8	3.6	0.9
Watson Chapel	7.5	25.1	9.0	4.5	2.0
Combined Mean of Target Area	**12.2**	**31.0**	**16.8**	**10.2**	**5.97**

The number of economically disadvantaged high school students (determined by those eligible for free or reduced school lunch) is also exceedingly high, with an average of 73.5%. During the 2015-16 academic year, nearly one in five high school students in the region dropped out. Between 2012-16, 40% of students did not go on to attend school beyond high school. Less than 50% in the region attended college within the first year of high school graduation.

Economically Disadvantaged Students & Educational Attainment by High School/School District

Partner High School/ School District	Percentage of economically disadvantaged students*	Drop Out of High School (2015-16)	Complete High School Only (2012-16)	Attend college within first year of high school graduation
Crossett	63.36%	16.1%	39.7%	50.9%
Dermott	94.46%	19.9%	42.0%	37.1%
Drew Central	73.21%	18.3%	36.9%	48.3%
DeWitt	61.97%	17.5%	40.6%	58.3%
Dollarway	93.29%	15.7%	38.4%	53.1%
Dumas	73.16%	23.9%	39.7%	50%
Fordyce	69.98%	16.6%	48.9%	39.8%
Hamburg	61.09%	16.1%	39.7%	50.9%
Hermitage	80.0%	20.1%	41.5%	48.1%
Lakeside	83.41%	19.9%	42.0%	37.1%
McGehee	73.20%	23.9%	39.7%	50%
Monticello	54.90%	18.3%	36.9%	48.3%
Magnolia	70.55%	14.8%	39.2%	52.2%
Pine Bluff	86.39%	15.7%	38.4%	53.1%
Stuttgart	64.12%	17.5%	40.6%	58.3%
Warren	72.02%	20.1%	41.5%	48.1%
Watson Chapel	74.31%	15.7%	38.4%	53.1%
Combined Mean of Target Area	**73.50%**	**18.2%**	**40.2%**	**49.2%**

* *Determined by National School Lunch Program (2015-2016)*, Arkansas Board of Education, United States Department of Agriculture; Economic Research service, ADHE

If the student beats the odds to successfully enter an undergraduate or graduate degree program, there are still significant academic and economic barriers to overcome. The table below demonstrates the high percentage of students at local colleges & universities qualifying as economically disadvantaged and the great need for financial assistance (self-reported data, partner colleges & universities, 2015-2016).

Student Need, Based on Financial Aid at Participating Colleges & Universities, 2015-2016

	Total School Enrollment	Pell Grants	Estimated # economically disadvantaged*	Federal Grants	Students taking out loans
Southeast Arkansas College	1,432	85%	1217	85%	29%
University of Arkansas-Monticello	3,854	41%	1580	72%	60%
Arkansas State University	13,144	46%	6046	54%	52%
Phillips Community College	1,797	76%	1365	100%	0%
East Arkansas Community College	1,270	64%	812	64%	5%
Southern Arkansas University	3,546	61%	2163	62%	54%
South Arkansas Community College	1,693	68%	1151	72%	22%
University of Arkansas-Pine Bluff	2,513	75%	1884	88%	65%

*** Number students receiving need-based financial aid/total school enrollment**

About Our Hospital

Mission

Chicot Memorial Medical Center is committed to providing extraordinary healthcare services and promoting healthy living in the communities we serve across Southeast Arkansas

Vision

Chicot Memorial Medical Center will provide the very best care for each of our patients as we position our organization to thrive in the evolving healthcare environment and become one of the very best rural hospitals in the country.

Values

Chicot Memorial Medical Center expects the very highest standards in human behavior and values the dignity of all people through the promotion of:

- Mutual respect for each other and our patients, treating each as we would want to be treated ourselves
- Trust in one another
- Commitment to the institution and the provision of quality health care
- Positive attitudes regarding the institution and our mission
- Open communication at all levels throughout the organization, both inter- and intra-departmentally

History

The original hospital in Lake Village was the Lake Village Infirmary, located on South Cokley Street. The Lake Village Infirmary served the Lake Village area well for many years, but in the early 1960s, the increasing need for a larger facility became more and more apparent, and plans for a new county hospital were made. In 1964, the people of the county, in addition to making generous contributions, voted a revenue bond issue of almost a million dollars.

Architects for the 50-bed hospital were Wittenberg, DeLong, and Davidson of Little Rock, Arkansas. The project was started under the late County Judge H. L. Locke and completed under Judge James R. Burchfield and placed in operation on October 30, 1967.

In 1975, thirty more beds were added, making a total of 80 beds. The expansion project was completed on December 6, 1976. It was paid for with revenue bonds, which were paid from the hospital operations.

In 1991, Chicot County citizens voted to increase the mill tax from .6 mill to 1 mill in support of ongoing maintenance for CMMC. On March 1, 2004, construction started on a new 45,000-square-foot patient care addition for CMMC to continue to provide quality care to our communities. This latest patient care addition was finished on February 15, 2006.

2019 Hospital Staffing Chart

See CMMC Staffing Chart in Attachments

2019 Hospital Governance

CHICOT MEMORIAL MEDICAL CENTER Board of Directors 2019	
SAMMY ANGEL, CHAIRMAN	TODD POTTER, VICE CHAIRMAN
David Holt, Secretary	Tommy Jarrett
Bill Elliott, Jr.	Linda Thomas
Judge Mack Ball, Jr. (Ex-Officio)	Dr. J.P. Burge

Providers

- Michael Bradley Mayfield, MD
- Autumn Bennett, WHNP
- Haley R. Burson, DMD
- J.P. Burge, MD, FACS

- Viviana Suarez, MD
- Benjamin P. Folk, III, MD
- Ned Kronfol, MD
- Robert L. Curry, IV, MD
- James Wright , DO, FAAFP
- Jo Anne Gregory, MD, FAAFP
- Chris Johnson, APRN

Other Area Providers

The major competitor providers in the service area are primarily private nonprofit, critical access hospitals and offer similar services. Several of those nearest to Lake Village are members of a regional collaborative, the Arkansas Rural Health Partnership, through which they work closely together to reduce costs by sharing services and negotiating contracts. One facility located in the larger community of Monticello is a county controlled rural hospital with 49 beds. Jefferson Regional Medical Center in Pine Bluff is 60 miles away with 471 beds.

LOCATION	HOSPITAL NAME	MEDICARE CLASSIFICATION	# OF LICENSED BEDS	HOME HEALTH	DISTANCE FROM CMMC
McGehee	McGehee Hospital, Inc.	Critical Access	25	Yes	22
DeWitt	DeWitt Hospital & Nursing Home	Critical Access	25	Yes	74.5
Dumas	Delta Memorial Hospital	Critical Access	25	Yes	44
Monticello	Drew Memorial Hospital	Rural	49	Yes	42
Pine Bluff	Jefferson Regional Medical Center	Regional	471	Yes	82
Warren	Bradley County Medical Center	Critical Access	25	Yes	59
Crossett	Ashley County Medical Center	Critical Access	25	Yes	48

Health Care Services

Chicot Memorial Medical Center offers a wide range of health care services geared toward the needs of the community in the Chicot County, Arkansas area. The services we provide at Chicot Memorial Medical Center include:

- Women's Health Services
- Ambulance/EMS Services, including Advanced Life Support for cardiac arrest

- Respiratory Services, including pulmonary function testing (PFT) and breathing treatments
- Surgical Services
- Medicine Assist Program

Home Health Care Services, including rehabilitative therapies and nursing care

- Inpatient Nursing Services
- Hospitalist Program, to help manage your care inside our hospital
- 24/7 Emergency Room, including a level 3 trauma care center
- Laboratory Services
- Radiology Services, including mammography, X-ray, and MRI
- Free community fitness center

For specialized medical care, Chicot Memorial Medical Center in Lake Village, Arkansas offers our patients access to a comprehensive set of outpatient clinics. Whether you require the services of a cardiologist, urologist, or another type of specialist, our skilled healthcare experts are available to keep you in the best of health.

- Cardiology
- Urology
- Women's Health
- Wound Care
- Nephrology
- Interventional Pain Clinic
- Sleep Medicine
- Surgical Clinic
- Chiropractic Clinic

Service Area

Chicot Memorial Medical Center's primary service area is Chicot County and its contiguous counties. Many surrounding areas do not have a hospital nearby to provide health services they require. The primary service coverage area includes all counties that border Chicot, including Desha and Ashley Counties of Arkansas and Washington County in Mississippi.

Community Health Initiatives

Chicot Memorial Medical Center is active throughout Chicot County in sponsoring health fairs, health education programs, free health screenings and other activities to promote the health of the citizens of Chicot County. CMMC is an active member of the Chicot County Hometown Health Initiative (HHI) which is a program of the Arkansas Department of Health. The Hometown Health Initiative (HHI) brings together a wide range of people and organizations including consumers, business leaders, and health care providers to develop and implement ways to solve health issues in each county. The HHI stresses:

- Collaboration
- Coalition building
- Prioritizing of health issues, and
- The development and implementation of community health strategies that are locally designed and sustained.

Chicot Memorial Medical Center also houses UAMS East and is an active member in the Arkansas Rural Health Partnership.

UAMS East

UAMS East is a seven county, health education outreach of the University of Arkansas for Medical Science, serving Chicot, Crittenden, Desha, Lee, Monroe, Phillips, and St. Francis Counties. This program was designed to increase access to health care by recruiting and retaining health care professionals and to provide health care to the whole family through community based health care and education. The program is headquartered in Helena with offices in Lake Village and West Memphis. Current Outreach Programs in Chicot County by UAMS include:

- CMMC/UAMS East Community Outreach Center
- Prescription Assistance Program
- Safety Baby Showers
- MASH/CHAMPS/AIM
- Club Scrub
- Child Passenger Safety
- Kids for Health
- Free Exercise Classes

- CPR/First Aid for Consumers and Health Professionals
- Health Fairs/Screenings
- Health Education for Children/Adults
- UAMS Preceptorship for Medical Students
- UAMS Senior Elective Rotations
- "A Day in the Life" Program
- Continuing Education opportunities for Healthcare Professionals
- Safe Sitter Course

Arkansas Rural Health Partnership

Chicot Memorial Medical Center currently participates in several health outreach efforts through its affiliation with the Arkansas Rural Health Partnership (ARHP). Arkansas Rural Health Partnership (ARHP), formerly known as Greater Delta Alliance for Health) is a 501(c)3 non-profit, horizontal hospital organization comprised of twelve, independently owned, South Arkansas rural hospitals committed to working together throughout the South Arkansas Delta region to: Improve the delivery of healthcare services, Increase access to health care services & programs, Provide healthcare provider education opportunities, Increase the utilization of tele health & tele medicine technology, Promote healthy lifestyles, Assist community members with patient assistance programs, and Reduce service & operational costs for hospital members through collaborative negotiation and purchasing. Arkansas Rural Health Partnership members include Ashley County Medical Center (Crossett, AR), Baptist Health-Stuttgart (Stuttgart, AR), Bradley County Medical Center (Warren, AR), Chicot Memorial Medical Center (Lake Village, AR), Dallas County Medical Center (Fordyce, AR), Delta Memorial Medical Center (Dumas, AR), Dewitt Hospital & Nursing Home (DeWitt, AR), Drew Memorial Health System (Monticello, AR) Medical Center of South Arkansas (El Dorado, AR), McGehee Hospital (McGehee, AR), Magnolia Regional Medical Center (Magnolia, AR), and Jefferson Regional Medical Center (Pine Bluff, AR). The organization was founded to help local hospitals address the financial burdens of their individual organizations and work to provide health outreach to the region through funding opportunities. Currently, ARHP provides the following outreach and education programs to its members, patients, and communities:

Healthcare Provider Training & Education

On-Site Simulation Trauma Training & Certification
On-Site Simulation OB Certification
On-Site Simulation Coding Training & Certification
On-Site Simulation ASLS Certification
On-Line Healthcare Education & Certification
On-Line Healthcare Orientation
Diabetes Site Accreditation Assistance
Diabetes Certification Assistance
DEEP training & certification
SAMHSA's SBIRT training
Medication Assistance for OUD Patients
Mental Health First Aid Training

Patient Education & Outreach Services

Opioid Use Disorder (OUD) Education & Navigation
Prescription Assistance Services
Free Breast Screening & Diagnostic Services
Cooking Matters Classes
Insurance & Medicare Assistance & Enrollment
Diabetes Prevention Program
Diabetes Empowerment Education Program (DEEP)
Mental Health First Aid Training
Opioid Use Disorder Case Management/Counseling
Patient Navigation
Emergency Department Mental Health Assessments
Diabetes Self-Management Education

Telehealth Services

Opioid Use Disorder Case Management/Counseling
Patient Navigation
Emergency Department Mental Health Assessments

Community Education & Outreach Services

Insurance & Medicare Assistance & Enrollment
Cooking Matters Classes
Diabetes Empowerment Education Program (DEEP)
Diabetes Prevention Program (DPP)
Opioid Use Disorder (OUD) Education
Mental Health First Aid Training
ArCOP Community Grants
Health Resource Directory
Health Fairs
EMT Certification

2016 CHNA Update

2016 CHNA Goals

Goal I. Align, Recruit, and Employ PCP Providers to meet unmet needs of the county	
OBJECTIVE	**ACTIVITIES**
To recruit Primary Care Providers to CMMC Medical Clinic in order to provide quality healthcare and to promote health living for not only our county but to surround areas; expand services in Rural Health Clinic	Continue to recruit healthcare physicians Focus on recruiting dentist, establishing a dental clinic with a full time Hygienist Through team work and partnerships work with other healthcare providers to provide additional services
Goal II. Provide Extraordinary Care at Cost Effective Rates	
OBJECTIVE	**ACTIVITIES**
To maintain quality measure performance while participating in Hospital Engagement Network (HEN) and closely monitor Patient Satisfaction scores, measure Quality Indicators in the Clinic areas, work with department directors to prepare for state survey, and increase medication scanning compliance and form a Patient Safety Committee	Provide extraordinary care for all patients Strive to be in top 10% within state on performance Maintain a zero rate or meet less than 40% reduction in the Hospital Engagement Network Achieve scores to be at or above National Average in every department of the hospital We will measure PQRS for our clinic providers and measure meaningful use indicators to assure that standards are met or exceeded
Goal III. To Become a Learning Organization by Leadership, Staff, and Board Development	
OBJECTIVE	**ACTIVITIES**
Educate our Executive team in the LEAN training and plan Board Development through education and retreat. Working with our Leadership Team	CEO will attend LEAN Training

and staff on additional training to help succeed at job.	Plan a Board Retreat for development and succession planning Individually tailor plans for each level of leadership for development and design a plan to build on each year.
Goal IV. Achieve fiscal stability by Development, Efficiency, and Waste Reduction	
OBJECTIVE	**ACTIVITIES**
Complete a comprehensive functional analysis to identify opportunity to reduce cost throughout the facility through teamwork of Department Directors	Create a Value Analysis Team Set up monthly meetings with billing company Perform a Charge Master review Establish an in-house coding team
Goal V. Expand our sphere of influence to compete with our competition and collaborate with our partners to educate the public on disease management and prevention	
OBJECTIVE	**ACTIVITIES**
We will offer public education programs to improve community health and wellness	Population health programs/education Communicate with LVC to support their needs Cosmetically upgrade our facility and fix front parking lot Consider partnering in the areas of dental, behavioral health, etc. Expand outpatient clinics Create robust plans for Compliance, Quality, and Risk Management Benchmark with other facilities on annual survey process In P&T discuss measure and reporting medication scanning rate to 100% Monitor Occurrences and form action plans to prevent patient harm
Maintain a strong relationship with Lake Village Clinic to align with them.	
Expand and develop our telehealth program especially in the area of consultation services for OB with UAMS for Ed and rural health clinic	

Goal VI. Expand access to services, technology, and expertise	
OBJECTIVE	**ACTIVITIES**
Consider feasibility of cardiology service line, out-patient Geriatric psych, pediatrics, orthopedics and vein clinics, and community center expansion for Dermott and Eudora. Plan specifically to market and grow all therapy services and develop a comprehensive marketing plan for CMMC	Continue to add services and access for patients and families Consistently market and promote hospital services and consider utilizing a marketing firm to develop and maintain the process

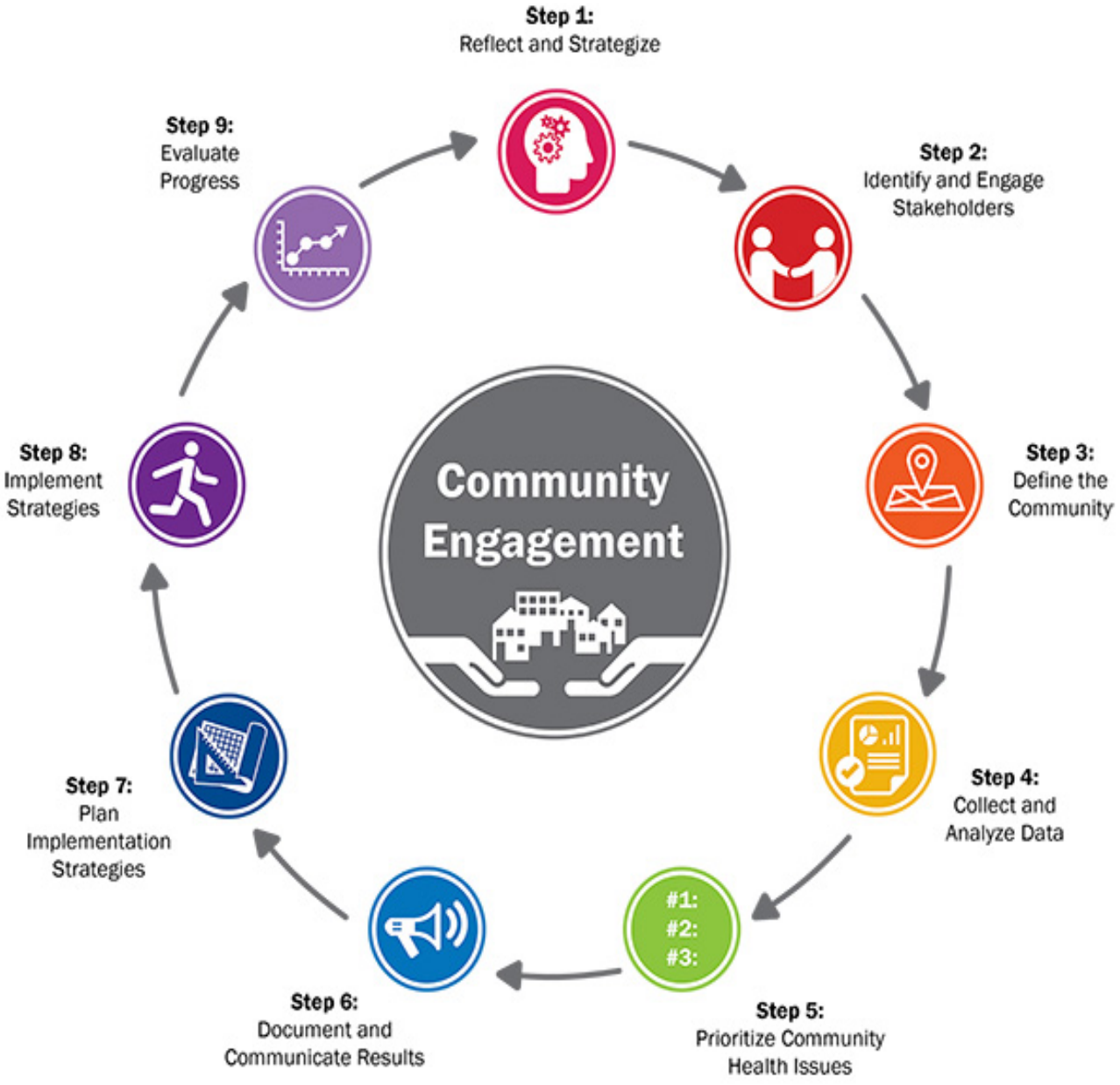
2016 CHNA Progress

Goal I. Align, Recruit, and Employ PCP Providers to meet unmet needs of the county
PROGRESS
❖ Continuing to recruit healthcare physicians by working with organizations to develop partnerships with our state colleges (new DO schools and MD school) ❖ Employed a dentist in our RHC as of November 2017and hired a part-time hygienist in the summer of 2018 ❖ As of January 2019 – 4 of the LVC providers are now rounding as our hospitalists
Goal II. Provide Extraordinary Care at Cost Effective Rates
PROGRESS
❖ HCAHP scores have risen and overall are above national average
Goal III. To Become a Learning Organization by Leadership, Staff, and Board Development
PROGRESS
❖ CEO attended LEAN Training ❖ Currently working with our leadership team and staff on additional training to help them succeed at their jobs (we are moving into this phase in the DRCHSD program)
Goal IV. Achieve fiscal stability by Development, Efficiency, and Waste Reduction

PROGRESS
❖ Full charge master review and implementation was completed in January 2019 ❖ We have 4 full-time coders and as of 2019 we have a 3rd party coding company that provides back-up coding, compliance and feedback
Goal V. Expand our sphere of influence to compete with our competition and collaborate with our partners to educate the public on disease management and prevention
PROGRESS
❖ All done or on-going
Goal VI. Expand Access to Services, Technology, and Expertise
PROGRESS
❖ Our marketing efforts are on-going

2019 Community Health Needs Assessment

Community Engagement Process



http://www.healthycommunities.org/Education/toolkit/files/community-engagement.shtml#.XEnj7bLru70

CHNA Facilitation Process

The Community Health Needs Assessment Toolkit developed by the National Center for Rural Health Works at Oklahoma State University and Center for Rural Health and Oklahoma Office of Rural Health was utilized as a guide for the CHNA facilitation process. The process was designed to be conducted through two community meetings. The facilitator and the steering committee oversee the entire process of organizing and determining a Community Advisory Committee of 20-30 community members that meet throughout the process to develop a strategic plan for the hospital to address the health needs of the community.

Overview of the Community Health Needs Assessment Process

Step 1: STEERING COMMITTEE
Select Community Advisory Committee Members
Select Community Meeting Dates
Invite Community Advisory Committee Members

Step 2: COMMUNITY MEETING #1
Overview of CHNA Process
Responsibilities of Community Advisory Committee
Present Health/Hospital Data & Services
Present Community Input Tool
Distribute Survey

Step 3: COMMUNITY MEETING #2
Present Survey Results/Outcomes
Group Discussion on Community Health Needs
Develop a Work Plan to Address Survey Results

Step 4: POST ASSESSMENT ACTIVITIES
Develop & Finalize Action Plan
Hospital Board Approval of CHNA Report
CHNA Report available to the Public
Report CHNA Activities/Plan to IRS

Public input is essential in the development of a Community Health Needs Assessment. To begin the process, the Chicot Memorial Medical Center staff steering committee members convened with Mellie Bridewell of the Arkansas Rural Health Partnership to assess community member involvement. The Chicot Memorial Medical Center (CMMC) staff steering committee included Julie Pennington (CMMC Marketing Director), Kim Rice (Executive Assistant/Materials Management), Chris Auerswald (CMMC Chief Financial Officer), and LaJuan Scales (CMMC Chief Nursing Officer. Mellie Bridewell, CEO of the Arkansas Rural Health Partnership and Lynn Hawkins participated and would provide assistance with organizing the community meetings as well as development of the assessment and strategic implementation plan.

Due to the size of the service area, the steering committee chose to conduct their assessment through a focus group of community leaders and individuals in health-related fields. Approximately 31 Individuals from the community were selected for invitation to the focus group, or community advisory committee, by the Chicot Memorial Medical Center staff steering committee. Those accepting the invitation – approximately 21 – attended the first meeting of the advisory committee. A few additional advisory committee members, who were unable to attend the first meeting, joined the second meeting after being briefed.

These community advisory committee members met initially to discuss health statistics affecting the hospital service area, and to individually complete the 2019 health needs survey. Advisory committee members assisted in the distribution of the surveys to neighbors, colleagues, and friends prior to the second meeting. Surveys were also available electronically on the CMMC website, the ARHP website, and various sites throughout the service area. At the second committee meeting, members were presented with the results of the surveys and discussed some of the questions and responses as a group and prioritize community health concerns. These priorities led the staff steering committee to develop a more detailed implementation plan to address those issues and create community benefit. Over the next three years, the action plans will be implemented for each issue and the hospital steering committee will meet annually with the advisory committee to assess progress.

Steering Committee

Mellie Bridewell	Chief Executive Officer	Arkansas Rural Health Partnership
Chris A	Chief Financial Officer	Chicot Memorial Medical Center
Kim Rice	Administrative Assistant	Chicot Memorial Medical Center
Luann Scales	Chief Nursing Officer	Chicot Memorial Medical Center
Lynn Hawkins	Chief Operations Officer	Arkansas Rural Health Partnership

Community Advisory Committee

Name	Address	Occupation
JoAnn Bush	P.O. Box 83 Lake Village, AR 71653	Former Mayor of Lake Village
Mayor Joe Dan Yee	210 Main Street Lake Village, AR 71653	Mayor of Lake Village
John & Jenn Conner	P.O. Box 587 Lake Village, AR 71653	County Extension Officer Lake Village Chamber of Commerce
Judge Mack Ball	417 Main Street Lake Village, AR	County Judge
Jeraldine Tucker	601 Rice Street Lake Village, AR	Former City Councilman
Theodore Brown	707 North Walnut Dermott, AR	
Sammy Angel	P.O. Box 748 Lake Village, AR	Lake Village City Councilman
David Holt	P.O. Box 326 Dermott, AR	CMMC Board of Directors
Linda Thomas	919 N. Mabry Street Eudora, AR 71640	CMM Board of Directors
Chief Percy Wilburn	210 Main Street Lake Village, AR 71653	Lake Village Chief of Police
Sheriff Ron Nichols	513 Main Street Lake Village, AR 71653	Chicot County Sheriff
Michele Crouse	401 Main Street Lake Village, AR 71653	Pharmacist/Business Owner
Dr. Jim Wright	2918 Louis Sessions St. Lake Village, AR 71653	Family Practice Physician
Mary Warfield	1736 S. Hwy 65 & 82 Lake Village, AR 71653	Arkansas Department of Human Services
Carli Edwards	1307 Park Street Lake Village, AR 71653	Business Owner
Stephanie Bierbaum	684 Hwy 144 North Lake Village, AR 71653	Community Health Champion
Barbara Harris	965 Hwy 160 W Portland, AR 71663	CMMC Auxiliary
Tisha Hayes	1415 US 65	Business Owner

	Lake Village, AR 71653	
Linda Haddock	466 S Lakeshore Drive Lake Village, AR 71653	Former Lake Village City Councilman
Billy Adams	1110 S. Lakeshore Drive Lake Village, AR 71653	Lakeside School Superintendent
Jennifer Brantley	192 Brantley Road Lake Village, AR 71653	Kindergarten Teacher
Jill Porter	1740 Hwy 65 & 82 Lake Village, AR 71653	Arkansas Department of Health County Unit Director
Chris Auerswald	2729 HWY 65 and 82 Lake Village, AR 71653	Chicot Memorial Medical Center Chief Financial Officer
Misty Rogers	2729 HWY 65 and 82 Lake Village, AR 71653	Chicot Memorial Medical Center
LaJuan Scales	2729 HWY 65 and 82 Lake Village, AR 71653	Chicot Memorial Medical Center Chief Nursing Officer
Kim Rice	2729 HWY 65 and 82 Lake Village, AR 71653	Chicot Memorial Medical Center Administrative Assistant/Purchasing
Julie Pennington	2729 HWY 65 and 82 Lake Village, AR 71653	Chicot Memorial Medical Center
Clint Payne	2729 HWY 65 and 82 Lake Village, AR 71653	Chicot Memorial Medical Center
Anna Scales	2729 HWY 65 and 82 Lake Village, AR 71653	Chicot Memorial Medical Center
Tara Gladden	2729 HWY 65 and 82 Lake Village, AR 71653	Chicot Memorial Medical Center Emergency Department Director
Dr. Brad Mayfield	2729 HWY 65 and 82 Lake Village, AR 71653	Chicot Memorial Medical Center Surgeon

Results Overview

There were 119 completed surveys through the 2019 CHNA process. All of the results of the survey can be found in Attachment G: 2019 CMMC Survey Results.

Top Issues Identified through CHNA Process
1. Need for more Mental and Behavioral Health Resources
Suggestions for addressing need: • Provide transportation for patients needing in-patient placement • Facilitate development of short-term facility • Increase mental and behavioral health resources at the local level
2. Need for Patient Assistance and Navigation Services
Suggestions for addressing need: • Provide Patient Navigators in the hospital and clinics • Provide training for insurance enrollment, Medicare, and assistance services • Provide community outreach (churches, events, salons, parent nights at schools) • Provide direct assistance with insurance and Medicare enrollment • Provide Billboards and Marketing of assistance services
3. Need for more Health Care Providers in Chicot County
Suggestions for addressing need: • Continue to provide clinical rotations for physicians and mid-level healthcare professionals in hospital and clinic • Increase the number of students participating in current MASH program • Participate in local nursing school job fairs • Host a hospital job fair
4. Need for healthy eating options in Chicot County
Suggestions for addressing need: • Provide in-house targeted healthy food demonstrations • Provide healthy eating options in the hospital (vending machine, gift shop) • Advertise CMMC food services as a local healthy food option • Host public market with local farmers • Encourage local food outlets to have healthier food options

Documentation

The following documentation of 2019 CHNA presentations, agendas, sign-in sheets, and survey results are included in the following attachments which can be found at the end of this report.

- **CMMC 2019 Staff Chart**
- **Attachment A.** Community Advisory Committee Meeting #1 Agenda
- **Attachment B.** Community Advisory Committee Meeting #1 Sign-in Sheet
- **Attachment C.** Community Advisory Committee Meeting #1 PowerPoint Presentation
- **Attachment D**. Community Advisory Committee Meeting #2 Agenda
- **Attachment E.** Community Advisory Committee Meeting #2 Sign-in Sheet
- **Attachment F**. Community Advisory Committee Meeting #2 PowerPoint Presentation
- **Attachment G.** 2019 CMMC Survey Results

2019-2021 Strategic Implementation Plan

The forthcoming implementation plan will include an individual action plan for each of the priority health issues identified in the Drew Memorial Health System needs assessment. As recommended by Mellie Bridewell, the Chief Executive Officer for the Arkansas Rural Health Partnership, and approved by the Internal Revenue Service, Chicot Memorial Medical Center will complete its implementation plan by July 2019, in conjunction with other ARHP member hospitals; all located in the South Delta region of Arkansas. While some concerns specific to the hospital may be included, most health issues affecting the Chicot Memorial Medical Center service area will be shared concerns among the other ARHP members. By crafting an implementation plan with input among these 11 hospitals, ARHP members anticipate widespread community benefit throughout the Arkansas Delta region through sharing of funding and other resources.

Qualifications of the Report Preparer

Mellie Bridewell, MSM

Ms. Mellie Bridewell, MSM is currently contracted to the Arkansas Rural Health Partnership as the Chief Executive Officer through the University of Arkansas for Medical Sciences (UAMS) Regional Programs. Mellie has eighteen years of experience in community and organizational networking, program development, grant writing, and program implementation. Mellie has been a critical component in the development of the Arkansas Rural Health Partnership organization which has grown from five founding member hospitals to the twelve member hospitals across the south Arkansas region.

Mellie has obtained over $10 million dollars in grant funds for Arkansas Rural Health Partnership to implement healthcare provide training opportunities, healthcare workforce initiatives, chronic disease programs, behavioral and mental health services, and access to care throughout the Arkansas Delta. Ms. Bridewell's reputation in the state of Arkansas and throughout the country as an ambassador for rural health infrastructure and rural health networks makes her the ideal facilitator for these assessments and plans. Ms. Bridewell was recently chosen as one of fifteen in the country to participate in the NRHA Rural Fellows program for 2019 and currently serves at Vice-President of the National Cooperative of Health Networks Association. Her ability to convene the appropriate partners and valuable stakeholders has led to state and national recognition. In 2016, Ms. Bridewell was acknowledged as a FORHP Rural Health Champion and the ARHP organization as a Rural Health Community Champion in 2017 for Collaborative Partnerships. She is known at the state and federal level for her ability to execute successful programs through collaboration with multiple partners and stakeholders. Mellie lives in Lake Village, Arkansas located in the Arkansas Delta region.

Ms. Bridewell has been designated to serve as a lead on ARHP hospital 2019 Community Health Needs Assessments due to her expertise in this area and the significant impact these assessments will have for the region that ARHP serves and well as the policy changes and program implementation essential to provide the needed services.